LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
ALCOHOL AND DRUG PROGRAM ADMINISTRATION
COST/ LINE ITEM REIMBURSEMENT

PROPOSITION 36 USE ONLY

PROVIDER NAME:_____ CONTRACT NO.:_____
ADDRESS:_____ CLAIM PERIOD:_____
CITY:_____ ZIP:_____ DATE PREPARED:_____
SERVICE CATEGORY:_____ PROVIDER NO.:_____
CONTACT PERSON:_____ PHONE:_____

ORIGINAL ◯ SUPPLEMENTAL ◯

Required for Proposition 36

CLIENTS SERVED: _____

UNITS OF SERVICE: **

DCH Visit Days: _____ **Individual Sessions:** _____
Residential Days: _____ **Group Sessions:** _____
Staff Hours: _____ **No. of Participants in Groups:** _____

Other Services

	UOS	# Clients	Amount
Literacy Training			$
Family Counseling			$
Vocational Training			$
Other Client Services			$

SECTION I - GROSS AMOUNT REQUESTED (Including Other services)

	BUDGETED LINE ITEM	AMOUNT CLAIMED THIS PERIOD*	TOTAL YTD AMOUNT CLAIMED	FOR COUNTY USE ONLY
1	SALARIES & EMPLOYEE BENEFITS	$	$	
2	SERVICES & SUPPLIES			
3	EQUIPMENT LEASES			
4	FACILITY RENT/ LEASES			
5	ADMINISTRATIVE OVERHEAD			
6				
7	TOTAL	$	$	

SECTION II - REVENUE

8	Grants	$
9	Client Fees	
10	Insurance	
11	Other	
12	TOTAL REVENUE (8 THRU 11)	$

SECTION III - NET AMOUNT REQUESTED

13	Gross Amount Requested (Line 7)	$
14	Total Revenue (Line 12)	$
15	NET AMOUNT REQUESTED (13 LESS 14)	$

Payment on this claim may be delayed or withheld if this request for reimbursement contains any errors or omissions. Form#3B-2 must be completed and attached to this claim.

COUNTY USE ONLY

Amount Requested: $_____
Carry Forward Amount: $_____
Total Amt. Payable: $_____

By _____ Date _____

LIMITED BY MONTHLY ALLOCATION

Total Amount Payable:
$_____

By_____ Date_____

Authorized Signature Date

*A separate sheet showing the details of the amounts shown in Column B must be attached.

** Based on Service Modality (e.g. Bed Days, Visits, etc.)